Waterloo Wellington
Regional Cancer Program
Ontario Health (Cancer Care Ontario)

Grand River Regional Cancer Centre
Cancer Genetics Referral Form

- Please fax this form to 519-749-2025. If you have questions or concerns, please call 519-749-4300, ext. 2832.
- **A FAMILY HISTORY QUESTIONNAIRE (FHQ) SHOULD BE COMPLETED BY THE PATIENT AND SUBMITTED WITH THE REFERRAL FORM.** The family history questionnaire is attached.
- Incomplete referrals (e.g. no FHQ) will not be processed and the referring provider will be notified.
- The completed referral and family history questionnaire will be reviewed by the genetics clinic to determine your patient's eligibility for a genetic counselling appointment.
- Genetic testing may or may not be offered in the course of a genetics consultation, pending eligibility.

Referral Eligibility	
Please complete the checklist on page 2.	
Is this assessment **urgent**? ☐ No ☐ Yes	Reason for **urgency** and timeframe (e.g. surgical decision/treatment planning):
Does the patient have a personal history of cancer? ☐ No ☐ Yes	Please include type, age at diagnosis, and pathology (include pathology report):
Does the patient have a family history of cancer? ☐ No ☐ Yes	**Please have your patient complete the attached family history questionnaire to the best of their ability including both affected and unaffected relatives.**

Patient Information	
Name (Last, First, Middle Initial):	DOB (yyyy-mm-dd):
Preferred Name:	Pronouns:
Sex: ☐ Male ☐ Female ☐ Other	Address:
Phone number:	Does the patient require an interpreter? ☐ No ☐ Yes
Email address:	Does patient consent to receive information by email? ☐ No ☐ Yes
Health card number:	Hospital chart number (if applicable):

Physician Information		
Referring physician:	Phone number:	Fax number:
Primary care provider:	Phone number:	Fax number:
Referring Provider Signature:	CPSO Number:	

Information Accompanying Referral (Required)
☐ Family Health Questionnaire (mandatory) ☐ Referral letter ☐ Pathology ☐ Family member's genetic test result ☐ Other:

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Hereditary Cancer Genetic Assessment Referral Guidance

Referrals ***should*** meet one or more of the following criteria. **Please check all of the boxes that apply.**

Personal and/or Family history of MULTIPLE CANCERS among close relatives on the SAME SIDE of the family:

Note: Genetic testing is best initiated in a family member with cancer – they should be referred first if possible.

☐ 2 or more breast/ovarian/prostate/pancreatic adenocarcinoma
☐ 2 or more breast/gastric
☐ 2 or more colorectal/endometrial/ovarian/gastric/pancreatic adenocarcinoma/ureter/renal pelvis/biliary tract/small bowel/ brain/sebaceous adenomas/sarcoma
☐ 2 or more malignant melanoma/pancreatic adenocarcinoma
☐ Multiple primary cancers in one individual

Personal and/or Family history of a close relative with YOUNG cancer:

☐ **Age 45 or younger** with breast or kidney cancer
☐ **Age 50 or younger** with cancer suggestive of Lynch syndrome[2]

[2]colorectal, endometrial, gastric/GE junction, small bowel, pancreas, hepatobiliary, ovarian, renal pelvis/ureter, glioblastoma, sebaceous neoplasm/keratoacanthoma with abnormal mismatch repair immunohistochemistry)

Personal and/or Family history of a close relative with RARE or STRONG HEREDITARY RISK cancer:

☐ Triple negative breast cancer ***≤60 years of age***
☐ Male breast cancer
☐ Ovarian Cancer
☐ Pancreatic adenocarcinoma
☐ High risk[1] or metastatic prostate cancer

[1] One or more features: T3 (or higher) staging, Grade Group 4 or 5/Gleason 8-10, lymph node involvement, PSA 20 or higher

☐ Abnormal mismatch repair immunohistochemistry on cancer pathology (suggestive of Lynch syndrome)
☐ Bilateral or multifocal renal cell carcinoma, or non-clear cell pathology
☐ Multiple adenomatous gastrointestinal polyps (10 or more at age 60 or younger, or 20 or more at any age)
☐ Pheochromocytoma or paraganglioma
☐ Medullary thyroid cancer

Cancer Gene Carrier:

☐ Confirmed hereditary pathogenic/likely pathogenic variant in a blood relative (e.g. BRAC1/2, MLH1/MSH2/MSH6, APC), please specify and include documentation (consult note/genetic test report):

_____

Ethnicity:

☐ Individual with breast, colorectal cancer/polyps, or prostate cancer **AND** ancestry with higher risk of hereditary cancer (e.g. Ashkenazi Jewish)

_____

Include all supporting documentation (e.g. pathology reports, including tumor, polyp and breast biopsies; family member's genetic test results) with the referral.

Grand River Regional Cancer Centre
835 King Street West, PO Box 9056
Kitchener, ON N2G 1G3
Fax: (519) 749-2025

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Genetics Assessment Questionnaire

Please answer the following questions:

Name:_____

Preferred Name:_____ **Pronouns:**_____

Has anyone in your family ever had genetic counselling and/or testing?☐Yes ☐ No
If yes, please answer the following questions:

Name of family member: _____

Relationship to you: _____

When and where they were seen: _____

Genetic test result (if done):_____

What is your ethnicity or family country of origin?

Mother's side: _____

Father's side: _____

Do you belong to a population with a higher incidence of hereditary cancer? e.g. Ashkenazi Jewish? ☐Yes ☐ No Specify _____

What are your main concerns/questions that you would like addressed at the genetics appointment?

_____

_____

_____

_____

Please complete the family history questionnaire to the best of your ability. Age and birthdates can be approximate. Please include all unaffected relatives in addition to affected relatives. ***It is important to note that sex refers to sex assigned at birth; if this differs from gender please indicate*.**

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HROBSP ADDENDUM

(Please only complete if assigned female at birth)

1) **Age at menarche (first menstrual period):**_____years old.

2) **Have you delivered any babies?** ☐ Yes ☐ No
   If yes: Date of birth for first baby: _____

3) **Have you entered menopause? Please check:**
   a. ☐ Still premenopausal/regular cycle,
   b. ☐ Perimenopausal: becoming irregular/starting to miss periods/having hot flashes or other symptoms
   c. ☐ Stopped completely at age: _____
   d. ☐ Had complete hysterectomy with removal of both ovaries at age: _____
   e. ☐ Don't know (had hysterectomy/ablation but ovaries not removed, no symptoms)

4) **Have you ever taken oral contraceptives?** ☐ Yes ☐ No
   If yes: For how many years? _____

5) **Have you ever taken hormone replacement therapy/HRT?** (i.e. estrogen to relieve post-menopausal symptoms, this includes oral/pill, patch, cream (please specify)?
   a. When did you start? _____
   b. When did you stop? _____

6) **Height** (feet/inches or cm) _____**Weight** (pounds or kgs) _____

7) **Have you ever had a mammogram?** ☐ Yes ☐ No
   If yes: Please list when/where_____

8) **Have you ever had a breast biopsy (had a needle to remove tissue/fluid from your breast or had a surgery to remove a lump from your breast)?**
   When: _____
   What hospital: _____

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Name (Please Print) Last, First, (Maiden in Brackets)	M/F	**Date of Birth** (M/D/Y)	**If deceased,** *list year or age of death.*	**Cancer Type** (e.g. breast, or none if never had)	**Age at Diagnosis**
YOUR NAME					
YOUR MOTHER'S NAME					
YOUR FATHER'S NAME					
YOUR CHILDREN 1.					
2.					
3.					
4.					
5.					
6.					
7.					

Name (Please Print) Last, First, (Maiden in Brackets) **YOUR SIBLINGS** **(Please specify half siblings)**	M/F	**Date of Birth** (M/D/Y)	**If deceased,** *list year or age of death.*	**Cancer Type** (e.g. breast, or none if never had)	**Age at Diagnosis**	**# Children** *M*	*F*
1.							
2.							
3.							
4.							
5.							
6.							
7.							

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Name (Please Print) Last, First, (Maiden in Brackets)	**Approximate Year of Birth**	**If deceased,** *list year or age of death.*	**Cancer Type** (e.g. breast, or none if never had)	**Age at Diagnosis**
YOUR GRANDMOTHER (on your mother's side)				
YOUR GRANDFATHER (on your mother's side)				
YOUR GRANDMOTHER (on your father's side)				
YOUR GRANDFATHER (on your father's side)				

YOUR MOTHER'S SIBLINGS **Total # female _____ Total # male _____** Name: Last, First (Maiden in brackets) **(please specify half siblings)**	M / F	**Approximate Year of Birth**	**If deceased,** *list year or age of death.*	**Cancer Type** (e.g. breast, or none if never had)	**Age at Diagnosis**	**# Children** *M*	*F*
1.							
2.							
3.							
4.							
5.							
6.							
7.							

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YOUR FATHER'S SIBLINGS **Total # female:_____ Total # male:_____** Name: Last, First (Maiden in Brackets) **(Please specify half siblings)**	M /F	**Approximate Year of Birth**	**If deceased,** *list year and/or age of death*	**Cancer Type** (e.g. breast, or none if never had)	**Age at Diagnosis**	**# Children** *M* *F*	
1.							
2.							
3.							
4.							
5.							
6.							
7.							

OTHER FAMILY MEMBERS diagnosed with cancer e.g. Cousins, nieces and nephews, great-grandparents, great aunts and uncles, grandchildren						
Name (Please Print) Last, First, (Maiden in Brackets)	M/ F	**Approximate Year of Birth**	**Relationship to you and name of parent** *(e.g. cousin, John Doe's daughter)*	**If deceased,** *list year or age of death.*	**Cancer Type** (e.g. breast)	**Age at Diagnosis**
1.						
2.						
3.						
4.						
5.						
6.						
7.						

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OTHER FAMILY MEMBERS continued						
Name (Please Print) Last, First, (Maiden in Brackets)	M/ F	**Approximate Year of Birth**	**Relationship to you and name of parent** *(e.g. cousin, John Doe's daughter)*	**If deceased,** *list year or age of death.*	**Cancer Type** (e.g. breast)	**Age at Diagnosis**
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						